

Office of Vermont Health Access
312 Hurricane Lane Suite 201
Williston, VT 05495
(802) 879-5903 / (802) 879-5963 Fax

Prescription for Pulse Oximeters-all ages
(For use by Prescribing Physicians Only)

Date _____ Initial request ____ Renewal ____ Rental Only ____ Purchase ____

MD Instructions: Initial request for a Continuous Oximeter w/24 trending memory need only fill out Sections I, III & IV
Spot Oximeter, renewals and others fill out the entire form Sections I-IV

Please give this completed form to the patient or send directly to the DME supplier. DO NOT send to the Office of Vermont Health Access or to EDS. Thank you.

Section I

Patient Name _____ Medicaid ID _____
DOB ____/____/____ Age _____
Diagnosis (list all pertinent, be specific)

Hospital Admissions last 6-months: give dates, hospital and diagnosis (es): (additional pages may be attached if necessary)

Section II

Date patient last seen by:
Pulmonologist _____ Cardiologist: _____ Thoracic Surgery _____ Neonatology _____
Cardiac Surgery _____ NICCU/PICCU _____ Pediatrician _____ Other _____ (specify)
When is next follow-up appt? ____/____/____

Tracheostomy: Yes ____ No ____ Oxygen Requirement- % flow _____
Number of hours oxygen is needed each day: Continuously _____ Day _____ Night _____
Ventilator dependent: Yes ____ No ____ Weaning off of ventilator: Yes ____ No _____

Give recent oximeter readings, include range, average and dates. Describe fluctuation(s):

Has the caregiver been trained on how to use the pulse oximeter, interpret the readings and actions to take?
Yes ____ No _____

Describe specific treatment plan as it relates to adjustment of oxygen to oxygen saturation: (may attach additional pages if needed.)

Estimate the length of time oximeter will be needed: Less than 3mos _____ 6mos _____ 12mos _____
Greater than 12 months _____ if so please explain:

List other related equipment in the home:

Section III

Specific Pulse Oximeter

*Continuous w/24hr trending memory _____ *Continuous (non-hospital grade) _____ Spot check only: _____
alarms, memory print-out, ac/dc
(* Usually rental only, Spot is for purchase only)

Please explain why this model is the only model that will meet the needs of this patient at this time:

Section IV

Please Print

Requesting physician's specialty: _____
Facility or Group Practice Name: _____
Print physician's name: _____ Medicaid Provider No. _____
Physician's address: _____

Telephone _____ Fax _____

I certify that the item prescribed above is a medically necessary part of the course of treatment and is
neither for *precautionary* or "*standby*" purposes nor for caregiver convenience.

Physician's signature _____ Date: ____/____/____

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Section V

DME Provider Section

DME Provider must complete the following in order for this request to be processed.

Information on equipment being placed in home (if new) or already in home (if renewal):
Brand: _____ Model: _____
Model #: _____ Serial #: _____
Warranty: Yes _____ No _____ Terms: 90 day _____ 1-Year _____ 2-Year _____ 3-Year _____ Other _____ (specify)

Date Caregiver trained by Respiratory Therapist: ____/____/____

Name with credentials: _____

Date equipment last maintained: ____/____/____ Date Respiratory Therapist last visited home: ____/____/____

Procedure Code: (do NOT submit without this) _____ Date of Service ____/____/____ to ____/____/____

(Please Print)

I certify that the above described equipment is appropriate for the needs of the beneficiary as scripted out by the physician **and** is consistent with Vermont Medicaid's criteria for oximeters.

If there were any questions or discrepancy in what the physician ordered and the Medicaid criteria for coverage of oximeters we consulted with the ordering physician and documented the details of that consultation. And/or we consulted with the clinical staff at the Office of Vermont Health Access.

Supplier/Vendor Name _____ Provider # _____

Address: _____

Telephone # _____ Fax # _____ Rep Name _____

(PRINT)

DME Rep Signature: _____ Date: ____/____/____

Note: All records are subject to retrospective review by the Office of Vermont Health Access.